

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07233

CERTIFICATE OF DEATH

07217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb Life 51 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		19-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		d. STREET ADDRESS 306 N. First St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Annie		First M.	Middle	Last Adams	4. DATE OF DEATH Oct. 22, 1872	Month May	Doy 18 19 67
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 22, 1872	9. AGE (In years last birthday) yrs. 94	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Prettyman Stevenson				14. MOTHER'S MAIDEN NAME Sallie Sterling			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Virginia Catlin, Same as 2. abcd		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 8 days years.							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 5-18-67 19____, and that death occurred at 9 M, from causes and on the date stated above.							
22a. SIGNATURE <i>C. G. Rawley</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.		22d. ADDRESS Crisfield, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 20, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City or Town) (County) (State) Crisfield, Md.	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.				ADDRESS		25a. REC'D BY REGISTRAR MAY 22 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07240

CERTIFICATE OF DEATH

07218

1. PLACE OF DEATH

a. COUNTY

Somerset

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Marion Station

c. LENGTH OF STAY IN 1b

Adult life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Own home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

GEORGE

HENRY

BLAKE

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Jan 30, 1894

9. AGE (in years
last birthday)73
yrs.10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Blake

14. MOTHER'S MAIDEN NAME

Laura Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

Yes

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16. SOCIAL SECURITY NO.

218-05-8807

17. INFORMANT

Mrs. Nina Blake, Same as 2. abcd

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Myocardial infarction

INTERVAL BETWEEN
ONSET AND DEATH

12 hrs.

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 1920d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that (I) (this hospital) attended the deceased from Aug. 5, 1966 to May 4, 1967 that (I) (we) last
saw the deceased alive on May 4, 1967, and that death occurred at M, from the causes and on the date stated above.

22e. SIGNATURE

C. G. Rawley

M.O.

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.22b. DATE
SIGNED

5/22/67

22c. PHYSICIAN'S
NAME (Type)

C. G. Rawley, M. D.

22d. ADDRESS

Crisfield, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION (City, town or county) (State)

Burial

May 20, 1967

American Legion Cemetery

Crisfield, Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Bradshaw & Sons, Crisfield, Md.

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MAY 26 1967

Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07241

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07219

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital			d. STREET ADDRESS Box 11			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Male Negro		First Joseph	Middle WIOOWEO	Lost NEVER MARRIED <input checked="" type="checkbox"/>	4. DATE OF DEATH Blue Aug. 7, 1947	Month May 19	Year 14 1967	IF UNDER 1 YEAR Months 000	IF UNDER 24 HRS. Hours 000	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Grocery store			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zebedee Blue			14. MOTHER'S MAIDEN NAME Priscilla Sterling			Address Priscilla S. Blue Marion, Md.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 216-44-8244			17. INFORMANT Priscilla S. Blue			18. INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			Hemorrhage into right temporal and parietal lobe and ventricle from ruptured congenital aneurysm.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) C. G. Rawley, M. D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Crisfield, Md.						22. DATE SIGNED 5/16/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/67		23c. NAME OF CEMETERY OR CREMATORIAL Langford Cem.,		23d. LOCATION (City or Town) (County) (State) Marion Som. Md.				
24. FUNERAL DIRECTOR Norma Ward			ADDRESS Marion, Md.			25a. REC'D BY REGISTRAR DATE MAY 12 1967		25b. REGISTRAR'S SIGNATURE George Judge		
VR A15ME (3 6M 1/66)										

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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07242

CERTIFICATE OF DEATH

07220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ewell		c. LENGTH OF STAY IN Tb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own home		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) DORA GERTRUDE BRIMER		4. DATE OF DEATH May 15 1967	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH April 1, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME George Evans		14. MOTHER'S MAIDEN NAME Georgianna Pruitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-3316	
17. INFORMANT Mrs. Gertrude Evans, Same as 2. abcd		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (d) DUE TO		Heart Failure 2 hours	
		Coronary artery disease 5 years	
		Cardiovascular-renal disease 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Diabetes mellitus, chronic, mod			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Not an accident	
20c. TIME OF INJURY Month, Day, Year Hour a.m. None p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) None
21. I certify that (I) (this hospital) attended the deceased from July 1967 to May 15, 1967 , that (I) (we) lost saw the deceased alive on May 15, 1967 , and that death occurred at 10:45 A.M. from causes and on the date stated above.		20f. CITY OR TOWN (County) (State) Not an accident	
22a. SIGNATURE Thomas C. Gentry M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/22/67
22c. PHYSICIAN'S NAME (Type) Thomas C. Gentry, M. D.		22d. ADDRESS Ewell, Smith Island, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 18, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Ewell Cemetery
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		23d. LOCATION (City or Town) (County) (State) Ewell, Somerset, Md.	
		ADDRESS	25a. RECD BY REGISTRAR MAY 26 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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new
way
from
now
more
Kubiegs not tall
Kubiegs not tall well well well
so tall and stiff
so tall
so tall

so tall
so tall

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07243

CERTIFICATE OF DEATH

07221

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		b. COUNTY Somerset	
c. LENGTH OF STAY IN 1b 33 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		d. STREET ADDRESS 12 Pear Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mannie Middle R. Last Collins		4. DATE OF DEATH Month May Day 17 Year 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Mar. 9, 1882	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours 19		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Laurel, Del.		12. MOTHER'S MAIDEN NAME Hettie Gray	
13. FATHER'S NAME Arthur Record		14. INFORMANT Franklin L. Collins, Same as 2. abcd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-4418	
17. INFORMANT Franklin L. Collins, Same as 2. abcd		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Carcinoma, liver Secondary carcinoma, colon. Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, at _____, 19_____, fram causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE C. Rawley.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. C. G. Rawley, M.D.		22d. ADDRESS Crisfield, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City or Town) (County) (State) Crisfield, Md.	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR MAY 22 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07244

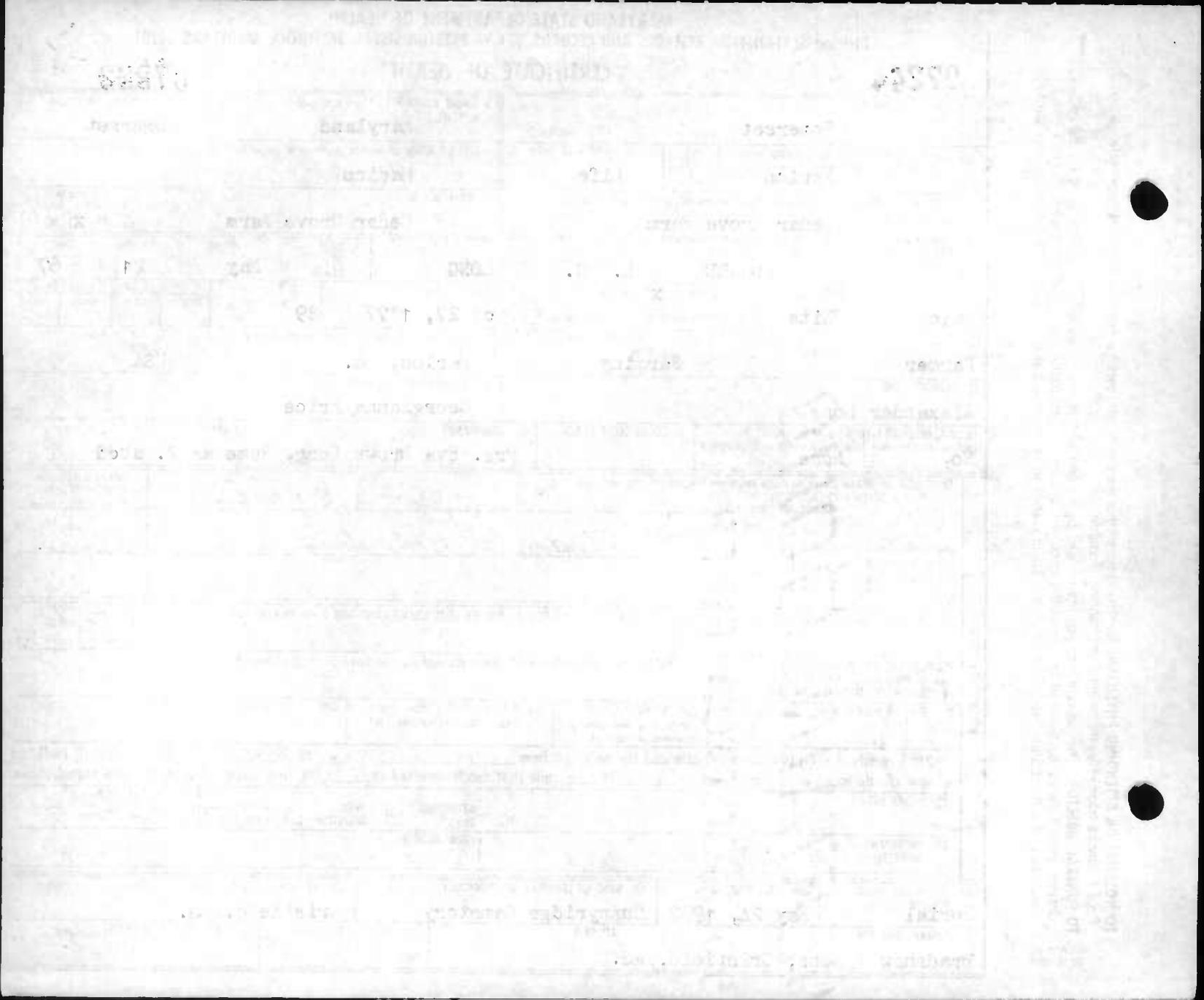
CERTIFICATE OF DEATH

07222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion	d. STREET ADDRESS Cedar Grove Farm	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cedar Grove Farm		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First EDWARD	Middle L. C.	Last LONG	
4. DATE OF DEATH May 21, 1967	Month May	Day 21	Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 27, 1877 89 9. AGE (In years last birthday) yrs. 100	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Marion, Md.	
13. FATHER'S NAME Alexander Long		14. MOTHER'S MAIDEN NAME Georgianna Price		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Eva Brown Long, Same as 2. abcd	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 45IX DUE TO Rupture of Descending Aorta INTERVAL BETWEEN ONSET AND DEATH 18 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Arterosclerotic Cardiovascular Disease known last. (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) Crisfield (County) Md. (State) 21817
21. I certify that (I) (this hospital) attended the deceased from Oct 27, 1967 to May 21, 1967 , that (I) (we) last saw the deceased alive on Feb 20, 1967 , and that death occurred at 12:42 P.M. from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE A. N. Barr, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/27/67	
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D.		22d. ADDRESS CRISFIELD, MD. 21817		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 24, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery	23d. LOCATION (City or Town) (County) (State) Crisfield, Md.	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.			ADDRESS	25a. REC'D. BY REGISTRAR DATE JUN 1 1967
				25b. REGISTRAR'S SIGNATURE Charles Judge

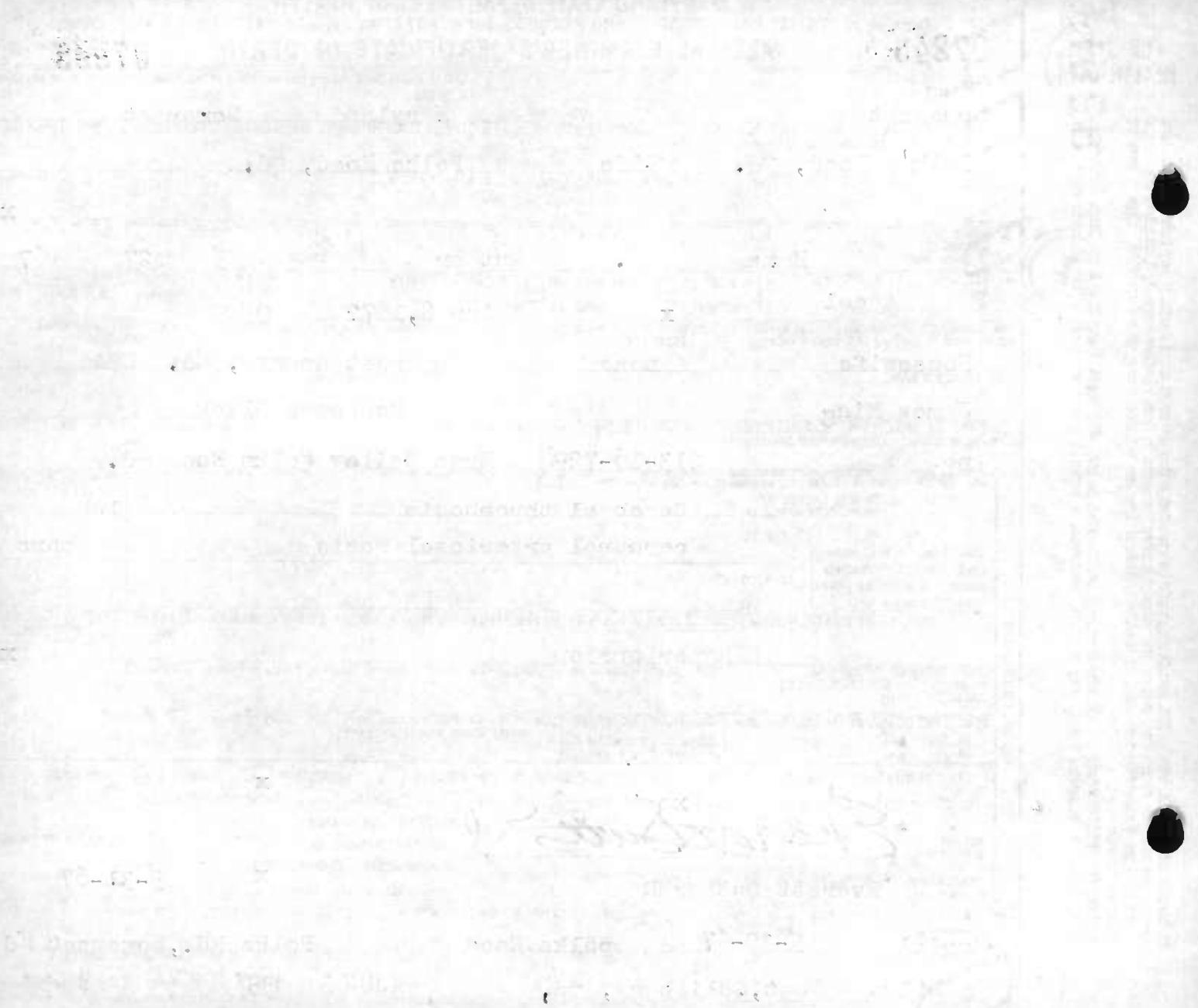


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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
07245				07223											
<p>1. PLACE OF DEATH a. COUNTY Somerset</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Polk's Road, Md.</p> <p>c. LENGTH OF STAY IN 1b Life</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>				<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland</p> <p>b. COUNTY Somerset</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Polk's Road, Md.</p> <p>d. STREET ADDRESS 191</p>											
<p>3. NAME OF DECEASED (Type or print) Emma K. Nutter</p>				<p>First Emma</p>		<p>Middle K.</p>		<p>Last Nutter</p>		4. DATE OF DEATH 5 27 1967	Month 5	Day 27	Year 1967		
5. SEX F		6. COLOR OR RACE col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH Apr 8 1872		9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (State or foreign country) Somerset County, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James King				14. MOTHER'S MAIDEN NAME Tennessee Black				Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-16-7294				17. INFORMANT Erma Bailey Polk's Road, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis												INTERVAL BETWEEN ONSET AND DEATH 1wk			
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				DUE TO cerebral arteriosclerosis								years 0			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) hypertension												19. WAS AUTOPSY PERFORMED? NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter natura of injury in Part I or Part II of Item 18.) Whilla Not While at work											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BBiks Road		20f. (City or town) Polk's Rd, Somerset Md.		(County) 0		(State) 0			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> Everett Sutter MD			
												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 5-31-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-30-67				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS BBiks Road				23d. LOCATION (City, town or county) (State) Polk's Rd, Somerset Md.			
24. FUNERAL DIRECTOR Hilda L West, Salisbury, Md.				ADDRESS				25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE JUN 5 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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07246

CERTIFICATE OF DEATH

07224

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb 7 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		e. STREET ADDRESS 113 Mariners Road	
77		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cecie Mae Outtend		4. DATE OF DEATH May 21 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 72 yrs.		10. DATE OF BIRTH Sept. 12, 1894	
11. BIRTHPLACE (County & State or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levin Phillips		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-8483	
17. INFORMANT Mrs Betty Riggan, Crisfield, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 180X IMMEDIATE CAUSE (a) <i>Tum Mycositidis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cerebral Metastasis</i> DUE TO last (c) <i>Carcinoma of Left Kidney</i>		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 mo. 18 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov.</i> , 1965, to <i>May 21, 1967</i> , that (I) (we) last saw the deceased alive on <i>5/21/67</i> , and that death occurred at <i>8:05M</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>5/22/67</i>	
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D.		22d. ADDRESS Crisfield, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-1967	
23c. NAME OF CEMETERY OR CREMATORIUM First Baptist		23d. LOCATION (City or Town) (County) (State) Pocomoke City, Wor. Md.	
24. FUNERAL DIRECTOR Robert H. Watson		25a. RECD BY REGISTRAR DATE MAY 26 1967	
Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07225

1		07247		2			
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		3			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE		4. DATE OF DEATH			
Somerset		MARYLAND		Month Day Year			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEAL ISLAND		c. LENGTH OF STAY IN b 65 yrs.		5. SEX			
d. NAME OF HOSPITAL (If not in hospital, give street address) AT HOME		d. STREET ADDRESS		6. COLOR OR RACE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	Month Day Year		
EVA				SHORES	MAY 5 1967		
7		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 81 yrs.			
W.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 3 - 1885	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
		TELEPHONE CO	MARYLAND	U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
BENJAMIN CULLISON		EVARINA GIBSON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
		UNKNOWN	EDITH FINNEE	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO	Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 3 mos		
		(b)	Coronary Arteriosclerosis				
		DUE TO			years		
		(c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m. p. m.		19	While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				
21. I certify that I attended the deceased from		1955	19	to	5-5	1967	that I last saw the deceased
alive on		5-5	1967	and that death occurred at	5P	M, from the causes and on the date stated above.	ADDRESS (Street) city or town, state)
ACTUAL SIGNATURE		Signature				DATE SIGNED	
PHYSICIAN'S NAME (Type)		James Guarter, M.D.				May 5-7-67	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		
BURIAL		5-8-67	ST. JOHN'S CEMETERY		DEAL ISLAND MD.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Leroy Webster		Princess Anne	DATE		MAY 10 1967 Charles Judge		

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07248

CERTIFICATE OF DEATH

Reg. Dist. No.

07227

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wenona		c. LENGTH OF STAY IN 1b lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wenona		d. STREET ADDRESS Main road				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home				d. STREET ADDRESS Main road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Evelyn		First	Middle	Last	4. DATE OF DEATH Taylor	Month	Day	Year		
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1915	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) household		10b. KIND OF BUSINESS OR INDUSTRY household		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William Stine				14. MOTHER'S MAIDEN NAME Mary V. Abbott						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT John Taylor		Address Wenona, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i> INTERVAL BETWEEN ONSET AND DEATH 6 mo DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Wenona		(County)	(State)	
21. I certify that I attended the deceased from <i>1956</i> , 19, to <i>May 1</i> , 1967, that I last saw the deceased alive on <i>May 1</i> , 1967, and that death occurred at <i>11 A M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Everett Sutter, M.D.</i> DATE SIGNED <i>5-3-67</i>										
PHYSICIAN'S NAME (Type) Everett Sutter		MD		Dames Quarter		Somerset Co MD				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4, 1967		22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery		22d. LOCATION (City, town, or county) Wenona		(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leroy Webster</i>		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR MAY 5 1967		24b. REGISTRAR'S SIGNATURE <i>Charles J. George</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07249

CERTIFICATE OF DEATH

07228

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<p>1. PLACE OF DEATH a. COUNTY Somerset MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield</p> <p>c. LENGTH OF STAY IN lb 8 days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shelltown</p> <p>d. STREET ADDRESS Rural</p>	
<p>3. NAME OF DECEASED (Type or print) First Helen Middle ---</p>		<p>Lost Toupet</p> <p>4. DATE OF DEATH Month May Doy 3 Year 1967</p>	
<p>5. SEX Female</p> <p>6. COLOR OR RACE White</p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>B. DATE OF BIRTH (?) 1892 75 9. AGE (In years lost birthday) yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY None</p>	
<p>11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penna</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Joseph Johnston, Sr.</p>		<p>14. MOTHER'S MAIDEN NAME Nellie Wallen</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>16. SOCIAL SECURITY NO. None</p>	
<p>17. INFORMANT Joseph Johnston, Same as 2. abcd</p>		<p>Address</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Renal Collapse DUE TO (b) Generalized ASHD</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 5 days</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>		<p>19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO</p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on May 3, 1967, and that death occurred 10:30 M, from causes and on the date stated above.</p>		<p>19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO</p>	
<p>22a. SIGNATURE H. C. Kaufman</p>		<p>22b. DATE SIGNED 5/4/67</p>	
<p>22c. PHYSICIAN'S NAME (Type) H. C. Kaufman, M.D.</p>		<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF May 5, 1967</p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL Rehobeth Meth. Cemetery</p>		<p>23d. LOCATION (City or Town) (County) (State) Rehobeth, Md.</p>	
<p>24. FUNERAL DIRECTOR</p>		<p>ADDRESS</p>	
<p>25a. REC'D BY REGISTRAR MAY 8 1967</p>		<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>	

1381 1381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07229**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
 5M 9/55

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1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dames Quarter		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dames Quarter, Md.	
d. STREET ADDRESS —		d. DATE OF DEATH Month May Day 27 Year 1967	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Richard	Middle Author	Last White
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-1907
		9. AGE (In years last birthday) 60	10. IF UNDER 1 YEAR Months 0 Days 0
		11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman-Nurseymen		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Dames Quarter, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George T. White		14. MOTHER'S MAIDEN NAME Lillie S. Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 443X		16. SOCIAL SECURITY NO. 220-10-3261	
17. INFORMANT Wife Priscilla		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X (b) Hypertensive cardiovascular disease DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Everett C. Sutter</i>		DATE SIGNED 5-29-67	
EXAMINER'S NAME (Type) Everett C. Sutter MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-30-67	
22c. NAME OF CEMETERY OR CREMATORIAL Macedonia		22d. LOCATION (City, town, or county) (State) Dames Quarter Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm H James III, Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE JUN 5 1967	
		24b. REGISTRAR'S SIGNATURE Charles Judge	

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